# KEARSLEY COMMUNITY SCHOOLS

## MEDICAL MASK EXEMPTION

All information must be complete prior to school approval and turned into your building office.

### 1. TO BE COMPLETED BY PARENT/GUARDIAN

| | | |
|---|---|---|
| | **Student Name:** | |
| | Grade: | |
| | Birthdate: | |
| | Parent Name: | |
| | Parent Phone: | |
| | Address: | |
| | Physician Name: | |
| | Physician Phone: | |
| | Release of Information: | Please release appropriate medical information to Kearsley Community Schools for the above named student. I authorize school personnel, the Genesee County Health Department, and the doctor listed on this form to share pertinent health information.<br>**Parent signature:** _____ **Date:** _____ |

### 2. TO BE COMPLETED BY PHYSICIAN

| | |
|---|---|
| | Student has been under my medical care since: |
| | Diagnosis of student's illness/condition: |
| | Symptoms causing student to be excluded from mandatory mask use at school and any exceptions: |
| | **Physician Signature:** _____ **Date:** _____ |

Comments:

### 3. TO BE COMPLETED BY BUILDING ADMINISTRATOR

| | |
|---|---|
| Approved | |
| Not Approved | |
| **Signature**: _____ **Date**: _____ | **Signature**: _____ **Date**: _____ |

**Comments**:

### TO BE COMPLETED BY SCHOOL NURSE